## **COUNTY OF LOS ANGELES**

MARVIN J. SOUTHARD, D.S.W. Director

DAVID MEYER
Chief Deputy Director

RODERICK SHANER, M.D.

Medical Director



BOARD OF SUPERVISORS
GLORIA MOLINA
YVONNE BRATHWAITE BURKE
ZEV YAROSLAVSKY
DON KNABE
MICHAEL D. ANTONOVICH

## **DEPARTMENT OF MENTAL HEALTH**

http://dmh.co.la.ca.us

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To: Name of Agency Telephone Number Fax:

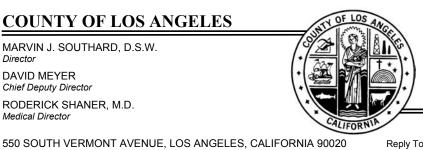
#200.2 Attachment III

Date
Name Address City, State, Zip Code
REF: REQUEST TO CHANGE PROVIDER
Dear:
This is to confirm our recent conversation regarding your request to change providers.
I am not able to grant your request at this time due to the following reason (s):
You currently have an appointment scheduled with (staff name) for (day/date) at (time).
If you have any questions or concerns, please feel free to call me.
Sincerely,
Program Manager

## **COUNTY OF LOS ANGELES**

MARVIN J. SOUTHARD, D.S.W. Director DAVID MEYER Chief Deputy Director

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## DEPARTMENT OF MENTAL HEALTH

http://dmh.co.la.ca.us

Reply To: Name of Agency Telephone Number

Fax:

#200.2 Attachment IV

Date
Name Address City, State, Zip Code
REF: REQUEST TO CHANGE PROVIDERS
Dear:
This is to confirm our recent conversation regarding your request to change providers.
Your new provider is (staff name).
An appointment has been scheduled for (day/date) at (time).
If you will not be able to keep this appointment, please notify our office by calling (phone number).
Sincerely,
Program Manager